RSC Republican Study Committee
http://johnshadegg.house.gov/rsc/
Rep. Mike Pence (R-IN), Chairman
Sheila Cole, Executive Director
426 Cannon House Office Building
Washington, DC 20515
ph (202) 226-9717 / fax (202) 226-1633

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Contents:

H.R. 4241 — Deficit Reduction Act (Title III)

Title III: Committee on Energy and Commerce

Background: Under the budget resolution (H. Con. Res. 95), the House authorizing committees were instructed to find savings to reduce the growth in mandatory spending. The House Energy and Commerce Committee was originally tasked with finding $14.7 billion in savings as part of a $35 billion package of savings over five years. Once the Republican Conference adopted the more ambitious goal of $50 billion in savings over five years, the Committee was expected to find additional savings.

Savings to Taxpayers: According to CBO, Title III would reduce federal spending and increase federal receipts (a credit against spending and therefore, a form of savings) by $17.1 billion over five years (see Table 1). Such savings amount to 31.7% of the $53.9 billion deficit reduction package.

Table 1. Savings By Subtitle, Outlays In Millions

Committee on Energy and Commerce (Medicaid)	2006	2006-10
Medicaid (Subtitle A)	-440	-11,877
Katrina Health Care Relief (Subtitle B)	2,515	2,553
Katrina and Rita Energy Relief (Subtitle C)	1,000	1,000
Digital Television Transition (Subtitle D)	7	-8,742
Total Savings		**-17,066**

Committee Action: On October 28, 2005, the House Energy and Commerce Committee reported its submissions to the House Budget Committee to be compiled into one reconciliation package along with the submissions of the other authorizing committees. On November 3rd, the Budget Committee reported the package, the Deficit Reduction Act, for consideration by the full House of Representatives.

Medicaid Savings in Perspective: Enacted in 1965, Medicaid has yet to undergo a comprehensive reform. However, as an entitlement with over 50 million enrollees, the program is set to grow at 7.7% annually over the next ten years. By 2040, Medicaid, along with Social Security and Medicare, will consume the entirety of today's budget as these program absorb the retirement of the Baby Boom generation. Since the states shoulder much of the cost of the program, they too are increasingly unable to meet their Medicaid obligations. In fact, according to the House Budget Committee, since 2005, all states reduced Medicaid provider payments, 38

states reduced eligibility, and 34 reduced benefits. This legislation would *slow the growth* of Medicaid from 7.7% to 7.5% over the next ten years and embrace many of the individual reforms recently endorsed the National Governors Association.

In addition, numerous OIG and GAO reports have outlined many examples of waste, fraud, abuse, and shortcomings of the current Medicaid system. For example, the most recent Health and Human Services, Office of the Inspector General Semi-annual report to Congress, cites the following examples:

- Schering-Plough Corporation agreed to pay $345.5 million related to the supposed illegal pricing of an allergy drug (Claritin) under the Medicaid drug rebate program;
- In a study of only three states, nursing facilities were running funding deficits ranging from $290,000 to $25 million, and the states were failing to match the federal government's funding; and
- In FY04, HHS Office of Inspector General, in connection with the states, recovered over $572 million due to convictions for Medicaid fraud.

Summary by Subtitle

Subtitle A: Medicaid, Summary by Chapters

Chapter 1: Prescription Drug Reforms

Table 2. Prescription Drug Reforms Savings/Spending, Outlays In Millions

	2006	2006-10
Prescription Payments—Federal Upper Limit	0	-1,900
Rebates on Physician-Administered Drugs	-5	-70
Authorized Generic Drugs Included in Best Price	-20	-220
Children's Hospitals Included in 340B Program	*	*
Limit Use of Prior Authorization for Antidepressant Drugs	0	125
Total: Chapter 1, Prescription Drug Reforms	**-25**	**-2,065**

* between -$500,000 and $500,000

- **Prescription Payments—Federal Upper Limit**:
  Adjusts Medicaid payments to pharmacists by basing them on "retail average manufacturer price" (RAMP) instead of the current system, which is based on the average wholesale price (AWP). RAMP is defined as the average price paid to a manufacturer for the drug in the United States by wholesalers for drugs distributed to retail pharmacies (excluding mail-order pharmacies). In addition, the definition for RAMP includes a detailed list of discounts given by manufacturers to certain buyers, which are to be included in the calculation of RAMP.

  In addition, the legislation establishes a new federal upper payment limit (the federal share of Medicaid drug reimbursements) and prohibits federal funding for payments of Medicaid-covered outpatient drugs, if the cost of the drug is in excess of those limits. Upper payment limit is defined for a single-source drug, as 106 percent of the RAMP, or for a multiple-source drug, as 120 percent of the RAMP.

  Although states would continue to determine their respective dispensing fees, the legislation requires states, under most circumstances, to establish dispensing fees of not less than $8 per

prescription (up from the current national average of $4), for covered outpatient multiple-source drugs, and directs states providing medical assistance for covered outpatient, drugs to pay a dispensing fee for each drug for which Federal financial participation is available. Additionally, states are given flexibility to vary the dispensing fee based on certain circumstances including pharmacies serving rural and "underserved" areas and sole community pharmacies.

Additional Information: GAO, HHS Office of the Inspector General, among others, have reported that calculating Medicaid payments to pharmacists based upon average wholesale price (AWP) is not a good measure of actual prices, is over inflated, and provides large room for overpayments. Additionally, all information regarding prices reported to the Secretary of HHS, though the Center for Medicare and Medicaid Services (CMS) by the manufacturers is, under current law, not allowed to be disclosed or made available outside of CMS. The proposed legislation replaces AWP with RAMP and makes public all information reported to CMS by the manufacturers, in hopes of limiting inflated drug prices and costs and to align Medicaid reimbursement to what it actually costs pharmacists to purchase drugs from the manufacturers.

Currently, many states require manufacturers to pay them (the states) a rebate for the use of their drugs in the Medicaid program. This rebate generates revenue for the states, which some use to offset their Medicaid costs and others spend as general revenues. Under current law, the rebate is calculated based upon average manufacturer price (AMP), which is very similar to RAMP. By calculating Medicaid payments to pharmacists through RAMP (instead of AWP), this bill will result in the manufacturers' rebate and Medicaid drug payments to pharmacists being calculated on similar formulas.

- **Judicial Review:** Prohibits any administrative or judicial review of a number of provisions in the bill, including the Secretary's determinations of federal upper limits, RAMPs, and the Secretary's disclosure to states of the average manufacturer prices. In other words, the bill protects against lawsuits attempting to overturn these decisions by the Secretary.

- **Reports**: Requires GAO to study the appropriateness of payment levels to pharmacies for dispensing fees under the Medicaid program. In addition, HHS, Office of the Inspector General must submit to Congress reports examining (1) the appropriateness of using the RAMP and (2) the payment to specialty pharmacies.

- **Outside Contractors:** Permits the Secretary of HHS to hire an outside contractor to collect and compile the information submitted to CMS by the manufacturers regarding their average prices. The outside entity would also calculate RAMP. Currently, CMS handles this process internally.

- **Rebates on Physician-Administered Drugs**: Requires states to provide utilization and coding information to CMS for physician administered outpatient drugs. This provision will help CMS identify if manufacturers are not paying rebates for the drugs.

- **Authorized Generic Drugs Included in Best Price:** Provides that manufactures are to report to the Secretary of HHS the AMP for covered outpatient drugs, including authorized generic drugs (many of which are being produced by the brand name company or a subsidiary company thereof) or any other drugs sold under a new drug application to the

current drug manufacturer reporting requirements. In addition, manufacturers must report their best price for single-source drugs, innovator multiple-source drugs, authorized generic drugs and any other drugs sold under a new drug application. The bill specifically includes authorized generic drugs in the reporting requirements for manufacturers regarding average manufacturer price reporting.

Additional Information: Under current law, manufacturers are required to give rebates to states to ensure Medicaid pays comparable to the manufacturer's "best price." Discounts are routinely offered to large drug purchasers, and the rebates are designed to guarantee that states pay the best price offered by the manufacturer to any other major purchasers. This system offers an incentive to drug manufactures to push up all of their prices to account for this discount. Manufacturers of brand name drugs are beginning to produce generic drugs in house, or are allowing a subsidiary company to produce the generic drugs, before the company's patent on the drug expires. This is known as "authorized generics." Under the current structure, the best price for authorized generic drugs is not included in the formula for determining best price, which affects to the amount of rebate the state gets back from the manufacturers. The bill provision requires the best price for authorized generic drugs to be included in the calculation and is predicted to increase the manufacturers' rebate to the states, although some have predicted that manufactures will stop providing generic drugs through Medicaid, rather than pay higher rebates. Other types of generics, just not these authorized generics, will continue to be available through Medicaid.

- **340B Program**: Allows certain children's hospitals to purchase prescription drugs at discounted prices. Currently, community health centers and some disproportionate-share hospitals can purchase Medicaid drugs at discounted prices if they sell the drugs in their own internal pharmacy. This provision allows children's hospitals to do the same.

- **Limit Use of Prior Authorization for Antidepressant Drugs**: Permits states to place atypical antipsychotic (used for treating Schizophrenia) and antidepressant single-source drugs on a list of drugs requiring prior authorization, when it is not likely to harm patients or increase overall medical costs. In addition, the measure provides that if a request for these prescriptions is not responded to by a drew review board within 24 hours of the submission, a payment is automatically made to the pharmacy for a 30 day prescription of the drug.

  In short, the legislation makes it more difficult for states to require physicians to obtain permission before prescribing drugs to treat depression and other psychiatric conditions. Often, those receiving these types of drugs are particularly sensitive to variations in the drug (like those between brand name and generic) and reports indicate they can be harmed from missing even one day's dose.

Chapter 2: Reform of Asset Transfers

Table 3. Asset Transfer Reforms Savings, Outlays In Millions

	2006	2006-10
Look Back Period and Period of Ineligibility	-140	-1,490
Home Equity Limit	-30	-580
Treatment of Large Annuities	-20	-280
"Income First" Rule	-10	-90
Continuing Care Retirement Communities' Fees	-10	-80
Total: Chapter 2, Asset Transfer Reforms	**-210**	**-2,520**

- **Look Back Period and Period of Ineligibility:** Changes (from 3 to5 years) the length of time in which a state may look back into the assets and disposal thereof by individuals attempting to qualify for Medicaid nursing home benefits.

  In addition, the legislation changes the start date for the period of ineligibility for those who transfer assets below fair market value, to the beginning of when the individual becomes eligible for Medicaid *and* receives services, instead of the current start date, which is simply the day the assets are transferred.

  Additional Information: It is common practice for seniors to transfer assets for less than fair market value, as well as their savings, to relatives or other individuals, to become impoverished enough to qualify for certain Medicaid coverage. In 1997, the National Academy of Elder Law Attorneys (NAELA) offered a seminar outlining principles of "advanced Medicaid planning," which detailed various ways for the elderly, married couples and single individuals to divert their assets and savings in order to qualify for Medicaid nursing home care. These suggestions included:

  - Getting a divorce
  - Purchasing a new wardrobe and anything else you may want
  - Paying off a home equity loan
  - Creating a limited partnership trust to make the money an "inaccessible asset," which does not count toward an individual's worth when applying for Medicaid.

  Under current law, there is a penalty period for an individual who transfers assets. It is calculated by dividing the value of the transfer by the average amount of money the individual would have spent monthly in a nursing facility. The resulting number translates into the number of months the person remains ineligible for Medicaid. This penalty period begins on the day the assets were transferred, which means that the period typically expires before the individual is even receiving Medicaid assistance. By changing the start date to the day the individual is enrolled in Medicaid and receiving care, the individual will be required to use his own money to pay for the months of nursing care equal to the period of ineligibility (penalty period). For example, if an individual gives his adult child a house worth $100,000, and the average monthly cost for a local nursing facility is $5,000, the individual would be given a penalty period of 20 months, in which they would be required to pay for his own care. These provisions are to apply to transfers made on or after the date of the enactment of this Act.

  $$\frac{\$100{,}000 \text{ (value of transfer)}}{\$5{,}000 \text{ (cost of local care)}} = 20 \text{ (months of penalty period)}$$

- **Hardship Waivers:** Directs each state to provide for a hardship waiver process to be used if application of the asset transfer provision will deny the individual life saving care or food, clothing, shelter, or other necessities of life. In short, a Medicaid applicant receiving a penalty period under the transfer of assets provision, may apply for an undue hardship waiver.

  Current law provides for the undue hardship waiver (which is rarely used according CRS), however, this provision encourages states to "promote" the waiver to Medicaid participants, by requiring states inform Medicaid recipients of their right to apply for a waiver.

- **Home Equity Limit:** Provides that an individual is not eligible for long-term care services if the individual's equity interest in his home exceeds $500,000. Beginning in 2011, the $500,000 limit is to be increased for inflation. This provision will not apply if the individual's spouse, children under the age of 21, or child who is blind or disabled, are living in the home, and the Secretary is directed to establish a process for waiving this provision in light of demonstrated hardship. Under current law, the value of the applicant's home is not considered while determining eligibility, meaning, if an individual owns a home worth $1 million, it is not taken into consideration when determining the individual's need for Medicaid assistance.

- **Treatment of Large Annuities:** Provides that a state must require that, as a condition for providing long-term care, an individual disclose the following information:
  - a description of any interest the individual has in an annuity regardless of whether the annuity is irrevocable or treated as an asset; and
  - full information concerning any transaction involving the transfer or disposal of assets during the previous five years, if in excess of $100,000

  In the case of any annuity in which an institutionalized individual or "community spouse" (spouse not receiving Medicaid) has an interest, if long-term care is provided to him, the state becomes the remainder beneficiary in the first position for the total amount paid on behalf of the individual for medical assistance. Meaning the state would be reimbursed for services rendered through the individual's annuity. Under current law (the Estate Recovery Program), states are required to recover their Medicaid costs through access to assets in probate, but accessing annuities for the same purpose is only *allowed, not required*.

- **"Income-First" Rule:** Requires that, if the community spouse needs additional income, the institutionalized spouse's income is the first fund from which payments to the community spouse should be derived. Only after the institutionalized individual's income is depleted, is the individual permitted to use other resources, such as transferring assets, to supplement the community spouse's monthly income.

  Under current law, certain protections guard against "impoverishment" of the community spouse of an individual attempting to receive long-term care. For example, the community spouse is permitted to possess some assets such as a house and car, without these items being counted as part of his spouse's assets for the purposes of qualifying for Medicaid. In

addition, the community spouse's income is not considered as available money during the process of applying for Medicaid edibility.

- **Continuing Care Retirement Communities' Fees:** Permits continuing care retirement communities or life care communities, including services in a nursing facility that are part of such communities, to require residents to spend on their care, resources that are declared for the purposes of admission, before applying for medical assistance.

  Continuing Care Retirement Communities (CCRCs) typically charge a resident a very large entrance fee (approximately $500,000). This fee is the individual's security that he or she may live in that facility and be cared for there for the remainder of his or her life. Any money that the individual has left over after paying the entrance fee is to be used to pay for his actual medical expenses while living in the facility. However, some residents choose to pay the entrance fee and then attempt to transfer the remainder of their assets and savings, in order to qualify for Medicaid assistance, instead of using one's own resources to pay for medical care. This provision allows CRCCs to *require* in their contracts, that individuals will not impoverish themselves after admittance to the facility. In addition, individuals are directed to use any of the entrance fee, if the facility provides that option, to pay for medical care after their own resources have been depleted and before they apply for Medicaid.

Chapter 3: Flexibility in Cost Sharing and Benefits

Table 4. Cost Sharing and Benefits Savings, Outlays In Millions

	2006	2006-10
Increasing Cost Sharing and Premiums	-70	-2,250
Alternative Benefit Packages	-150	-3,940
Cost Sharing for Prescription Drugs	0	-260
Non-Emergency Care Provisions	10	0
Non-Emergency Medical Transportation	15	-55
Exemption for Women with Certain Cancers	*	3
Total: Chapter 3, Cost Sharing and Benefits	**-195**	**-6,502**

*between -$500,000 and $500,000

- **Increasing Cost Sharing and Premiums:** Allows a state, the option of imposing premiums and cost sharing for any group of individuals and for most type of Medicaid services, exempting the following individuals and services:
  - Individuals under 18 years of age, automatically eligible for Medicaid;
  - Pregnant women;
  - Any terminally ill individual who is receiving hospice care;
  - Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required (as a condition of receiving services) to spend, for costs of medical care, all but a minimal amount of the individual's income required for personal needs;
  - Preventive services (such as well-baby and well-child care and immunizations) provided to children under 18 years of age, regardless of family income;
  - Certain emergency services; and
  - *Family planning services and certain supplies*

Under current law, states are permitted to require cost sharing. However, such cost sharing is limited to $3. In fact, a majority of those receiving Medicaid assistance do not pay any cost share for the services provided. The legislation directs the Secretary of HHS to increase the allowable state cost-share amount (called the "nominal amount"), over a period of three years, for those under the poverty level, from $3 to $5 by 2008. States are permitted to impose increased cost-sharing amounts for individuals with family incomes over the federal poverty level. In addition, the Secretary would increase the nominal amount beginning in 2009, for medical inflation. The bill places a limit of 5% of total income on the combined total of nominal amounts, premiums and cost sharing charged to families above the poverty line.

- **Enforcing Premiums and Cost Sharing**: Allows states the option of refusing to provide medical assistance to an individual who fails to pay a premium and to terminate eligibility for the medical assistance if the failure to pay continues for 60 days or more. States are allowed to waive this provision in case of undue hardship.

  The legislation allows states to permit a Medicaid provider to require, as a condition for receiving medical care, the payment of any cost sharing authorized under this Act, with respect to care, items, or services. However, the bill states, "Nothing in this paragraph [provision] shall be construed as preventing a provider from reducing or waiving the application of such cost sharing."

- **Alternative Benefit Packages**: Permits the states to provide medical assistance to individuals within one or more groups of beneficiaries, specified by the state, by enrolling them in various coverage packages ("benchmark packages"). Some of these packages could provide reduced coverage for those with certain incomes. The legislation provides that states could *not* reduce coverage for certain beneficiaries including among others, certain disabled individuals, pregnant women and children. The following plans are specifically listed to be considered to be benchmark coverage:
  - The standard Blue Cross/Blue Shield preferred provider option service benefit plan (for federal employees);
  - A health benefits coverage plan that is offered and generally available to state employees in the state involved; and
  - The health insurance coverage plan that:
    - is offered by a health maintenance organization; and
    - has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the state involved.

  The bill also provides an extensive, specific definition of what services and coverage will be considered to be actually equivalent to benchmark coverage. Current law is generally restrictive in nature and does not allow states to provide various types/ levels of benefit packages to different individuals based upon their income.

- **Cost Sharing for Prescription Drugs:** Allows states to increase cost sharing for drugs that are not preferred drugs within a class. States may waive or reduce the cost sharing otherwise applicable for preferred drugs within the class and may not apply the cost sharing for

preferred drugs to individuals for whom cost sharing may not otherwise be imposed (such as the poor and disabled). The bill places a limit of 5% of total income on the nominal amount, premiums and cost shares charged to families considered to be above the poverty line.

In addition, the legislation provides that if a physician determines that the preferred drug would be either ineffective or harmful to the individual, the state may apply the cost-sharing amount (used for preferred drugs) to the non-preferred product prescribed for the individual. States are also allowed to exclude certain drugs or drug classes from the cost-sharing regulations and must have a system for prior authorization and appeal procedures in order to implement these provisions.

Note: Provides that in no case, may a state treat as a non-preferred drug under this subsection a drug that is treated as a preferred drug under the TRICARE pharmacy benefit program or impose cost sharing under this subsection that exceeds the cost sharing imposed under the standards for the TRICARE pharmacy benefit program.

- **Emergency Room Copayments for Non-Emergency Care:** Permits states to impose cost sharing for non-emergency services furnished to an individual in a hospital emergency department if:
  - The individual has an alternate non-emergency services provider available, with respect to these services;
  - The physician or hospital informs the beneficiary, after appropriate screening assessment and before providing the non-emergency care, about the cost of care and the options for seeking different care.

  For individuals below the federal poverty level, cost-sharing fees could only be increased to twice the nominal amount (currently $3 increasing to $5 by 2008). Currently, states may apply for a waiver in order to increase these cost sharing fees, and this provision eliminates the need to apply for such a waiver.

- **Establishing Alternate Non-Emergency Services Providers:** Authorizes $100 million for a four-year period beginning inFY06, for payments to states for the establishment of alternative, non-emergency service providers. The legislation defines an alternative, non-emergency service provider as "a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that provides clinically appropriate services for such diagnosis or treatment of the condition within a clinically appropriate time."

- **Non-Emergency Medical Transportation**: Permits the states to establish a non-emergency medical transportation program in order to more cost-effectively provide transportation for individuals eligible for medical assistance who lack transportation.

  Under current law, states are required to provide transportation for Medicaid patients to and from appointments, etc. States can either offer transportation as an optional Medicaid service, or they may include it under their administrative costs. Different levels of federal matching rates and regulations apply to states, depending on which method they choose.

- **Women with Cancer Exemption**: Exempts women covered under the breast or cervical cancer program from all provisions in this chapter. Under current law, states can choose to provide Medicaid to certain women (under the age of 65) with breast or cervical cancer or who need early detection screening. This provision means that the reforms, such as the cost-sharing and benchmark packages, will not apply to the women covered under Medicaid.

Chapter 4: Expanded Access to Certain Benefits

Table 5. Benefit Expansions, Outlays In Millions

	2006	2006-10
Home and Community Based Services	0	815
Self-Directed Services Provisions	5	130
Long-Term Care Partnership Programs	0	10
Health Opportunity Accounts	5	60
Total: Chapter 4, Benefit Expansions	**10**	**1,015**

- **Home and Community Based Services:** Permits states to offer home care to qualifying individuals, instead of requiring that the individual be admitted to a nursing or long-term care facility. Under current law, states must apply for a waiver in order to provide one or more limited services at home. Under this provision, it would no longer be necessary to receive such a waiver.

- **Self-Directed Services:** Permits states to provide payment for part or all of the cost of self-directed personal assistance services to certain individuals in need of long-term care. A state would be required to provide a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets.

  Self-directed personal assistance services is defined as personal care and related services, or home- and community-based services otherwise available that are provided though an offered service, participants purchase personal assistance and related services, as well as personally hire, fire, supervise, and manage the individuals providing such services.

- **Long-Term Care Partnership Programs:** Repeals a current restriction on many states by permitting them to operate long-term care partnership programs that allow long-term care recipients to qualify for an exemption from the asset requirements if they later need nursing home care under Medicaid. The legislation outlines specifically which types of benefits are to be offered under this program, which income and asset requirements may be waived, and the specific restrictions placed upon states and the individuals participating in the program.

  Medicaid currently rewards individuals who have purchased private, long-term care insurance, by allowing them to more easily qualify for Medicaid after their private insurance has run out or expired. Typically, these individuals are permitted to retain assets and income higher than most Medicaid beneficiaries. However, current law provides that only states that had, before 1993, a federally approved plan to accept these types of patients, are allowed to operate such a program. This provision repeals that restriction, allowing states with approved plans after 1993 to also provide this benefit.

- **Health Opportunity Accounts:** Requires the Secretary to establish a demonstration program under which states may provide health opportunity accounts under their state plans, for the provision of alternative benefits for eligible population groups in one or more geographic areas of the state specified by the state. Under these health opportunity accounts (HOAs), the state (up to $2,500 per adult, including federal portion), the family members, other individuals or groups, and charitable groups could contribute to the accounts and the beneficiaries would use the money to pay for certain health care services, as outlined by the state.

  The demonstration project is to begin on January 1, 2006, and it is limited to only 10 state demonstration projects. After the five-year period, these demonstration programs are eligible to be extended or made permanent, and other states may establish such programs, at the Secretary's discretion.

Chapter 5: Other Provisions

Table 6. Other Provisions, Outlays In Millions

	2006	2006-10
Require Evidence of Citizenship	-5	-220
Restrictions on Provider Taxes	-5	-615
Third-Party Recovery	-20	-480
Targeted Case Management Services	-30	-760
Additional Funding for the Territories	20	140
Medicaid Transformation Grants	0	100
Payment for Emergency Services	0	-60
Modify Calculations of FMAPs	15	85
Non-Application to Katrina Evacuees	5	5
Total: Chapter 5, Other Provisions	**-20**	**-1,805**

- **Require Evidence of Citizenship:** Requires individuals enrolling in Medicaid to provide proof of their U.S. citizenship. Currently, an individual must only declare he or she is a U.S. and is not required to prove it. Some reports indicate many illegal immigrants are currently receiving Medicaid.

- **Restrictions on Provider Taxes:** Requires that taxes on managed care organizations (MCOs) apply to all similar organizations, including those not serving Medicaid participants.

  Under current law, many states tax health care providers in order to recover some of their Medicaid expenditures. If a state chooses to tax health care providers, certain provisions in current law require these states to tax an entire group or class of providers, if a tax is to be imposed on just one. However, the law presently allows states to individually tax MCO's providing Medicaid services.

- **Third-Party Recovery:** Provides that pharmacy benefit managers (and other "third parties") are liable for payment of a claim for a health care item or service. Although, under current law, these third parties are considered legally liable for Medicaid services, this provision

strengthens the current statue, and clarifies specifically which types of entities are liable and for what exactly they are responsible.

- **Targeted Case Management Services:** Supplements the current definition of "case management services" by outlining exactly what types of activities are to be funded under this section of Medicaid. Specifically, the legislation provides that the term case management service is to include the following:

  - Assessment of an eligible individual to determine service needs;
  - Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
  - Referral and related activities to help an individual obtain needed services; and
  - Monitoring and follow-up activities, including contacts necessary to ensure care plan is effectively implemented.

  Targeted case management is a benefit that states *may* offer to its enrollees intended to assist beneficiaries in gaining access to other services (educational, social, etc). Under current law, the term "case management services" is defined as services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. The above qualifications are added to clarify and narrow this definition, and specific exclusions are also listed.

- **Additional Funding for the Territories:** Increases the federal funding limit in FY06 and FY07 to the following territories by the following amounts:
  - Puerto Rico: $12 million in FY06 and $12 million in FY07
  - Virgin Islands: $2.5 million in FY06 and $5 million in FY07
  - Guam: $2.5 million in FY06 and $5 million in FY07
  - Northern Mariana Islands: $1 million in FY06 and $2 million in FY07
  - American Samoa: $2 million in FY06 and $4 million in FY07

  The bill provides that for FY08 and the following years, the annual limit on federal funding for Medicaid programs in each of the listed territories is to be increased for inflation. Under Medicaid, the 50 U.S. states are not given a specific limit for the federal share of Medicaid; rather, it is based upon a matching rate. However, the territories listed above are given an annual federal allotments for their Medicaid expenses.

- **Medicaid Transformation Grants:** Authorizes $100 million over two years for new payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance. States are **not** required to match federal funds to receive these payments. Specifically, the bill outlines the following methods to be included:
  - Methods for reducing patient error rates through the implementation and use of electronic health records and supplies;
  - Methods for improving rates of collection from estates of amounts owed;
  - Methods for reducing waste, fraud, and abuse under the program; and
  - Implementation of a risk management program as part of a drug use review program.

- **Payment for Emergency Services:** Requires any non-contract provider of emergency services to accept as payment in full, the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity.

- **Modify Calculations of FMAPs:** Provides that, for purposes of computing the federal medical assistance percentage (FMAP), the amount of money a state receives from the federal government, any employer pension contribution that exceeds a certain level is to be disregarded in computing the per capita income of the state (although it is not be disregarded in computing the national per capita income for the continental United States, Alaska and Hawaii).

- **Non-Application to Katrina Evacuees:** Assumes that none of the provisions in this title shall apply during the 11-month period beginning September 1, 2005, to individuals that qualify for Medicaid and are a resident in an area declared as a result of Hurricane Katrina.

Subtitle B: Katrina Health Care Relief

Table 7. Katrina Health Care Relief Spending, Outlays In Millions

	2006	2006-10
Temporary FMAP Increase for LA, MS, AL	2,470	2,463
State High-Risk Insurance Pools	45	90
Total: Subtitle B, Katrina Health Care Relief	**2,515**	**2,553**

- **Temporary FMAP Increase for LA, MS, AL:** Increases the federal share (FMAP) of Medicaid for the period beginning August 28, 2005, and ending May 15, 2006, for areas declared a disaster in Louisiana, Mississippi or Alabama, (to 100%, up from 70% in Alabama and Louisiana and 76% in Mississippi). In addition, the 100% federal match will apply to participants (children) in the State Children's Health Insurance Program (SCHIP).

- **State High-Risk Insurance Pools:** Authorizes $90 million in FY06 in new direct spending for high-risk pools. High-risk pools, typically operated by state-established entities that contract with private insurance companies, are designed to provide health insurance to individuals who cannot obtain or afford health insurance due to preexisting conditions or other reasons. Risk pool premiums are usually limited between 125% and 200% of market rates and do not cover operational costs given the high-risk nature of the insured individuals.

- **Health Care Waivers**: Directs the Secretary to identify areas that have been directly impacted by Hurricane Katrina or are located in a state which has absorbed a significant number of Hurricane Katrina evacuees and to determine which health care centers are located in "medically underserved areas." The Secretary is directed to waive several requirements for these entities, including certain governing board policies and some of the requirements for the entities regarding the provision of "primary health services." The provision sunsets in two years.

- **Hold Harmless:** Under current law, the state and U.S. per capita personal income statistics from the three most recent years are used to calculate the FMAP for each state on an annual basis. This provision requires that, for any year after 2006, if the Secretary of HHS determines that a significant number of individuals who were evacuated to, and live in, a state as a result of Hurricane Katrina (as of October 1, 2005), the income of these individuals is not to be included in that state's FMAP for Medicaid and SCHIP.

Subtitle C: Katrina and Rita Energy Relief

Table 8. Katrina and Rita Energy Relief Spending, Outlays In Millions

	2006	2006-10
Increase Funding for LIHEAP		1,000
Total: Subtitle C		**1,000**

Increase Funding for LIHEAP: Provides a one-time expenditure of $1 billion (in direct spending) for FY06 funding for Low-Income Home Energy Assistance (LIHEAP). This funding is designed to provide assistance to offset the anticipated higher energy costs caused by Hurricanes Katrina and Rita. The legislation sunsets this provision on September 30, 2006.

Note: Typically, LIHEAP is funded through the annual appropriations process.

New State-Government, Local-Government, or Private-Sector Mandates:
According to CBO, subtitles A, B, and C contain no intergovernmental or private-sector mandates.

Subtitle D: Digital Television Transition

Table 9. Digital Television Transition Savings, Outlays In Millions

	2006	2006-10
Spectrum Auction Proceeds	0	-10,000
Converter Box Subsidies	5	990
Interoperability Grants	0	235
NYC Television Reimbursement	2	30
Low-Power Transition Assistance	0	3
Total: Subtitle D, Digital Television	**7**	**8,742**

Background: As the Energy & Commerce Committee reports, in 1996, to facilitate the digital TV transition, Congress gave each full-power television broadcaster (for free) an extra channel of spectrum to broadcast in digital format while continuing to broadcast in analog format on its original channel. Each broadcaster was supposed to eventually return either the original or additional channel and broadcast exclusively in digital format on the remaining channel. In 1997, Congress earmarked for public safety use some of the spectrum the broadcasters are supposed to return. Congress designated the rest of the spectrum to be auctioned for advanced commercial applications, such as wireless broadband services. Congress set December 31, 2006, as the deadline for broadcasters to return the spectrum for public safety and wireless use.

However, a "loophole" allows broadcasters in a market to delay the return of the spectrum until more than 85% of TV households in that market have at least one TV with access to digital broadcast channels using a digital television receiver, a digital-to-analog converter box, or cable or satellite service. Experts forecast it will take many more years to meet the 85-percent test nationwide.

The Committee further writes that "DTV offers sharper and wider pictures, and CD-quality sound. Even consumers with analog televisions connected to a converter box or cable or satellite service will receive better service than they did before the transition."

Once the transition is complete, the Committee argues, broadcasters will be able to redirect the resources they currently expend running both analog and digital stations and "focus on programming that capitalizes on the advanced features of digital transmissions." Manufacturers will also be able to increase the production of TVs and other consumer electronics equipment that takes advantage of these features, "which will also drive down prices." The cleared spectrum will also be able to be used to bring "cutting-edge" wireless services to public safety officials and consumers. This spectrum travels greater distances at lower costs and "more easily penetrates buildings and foliage." Consequently, the Committee contends, "it is ideal to bring mobile broadband services not only to urban areas, but to rural areas as well, which currently have very few cost-effective broadband options."

FCC Spectrum Auction: Amends existing law regarding the Federal Communications Commission's (FCC) authority to auction licenses to use the electromagnetic spectrum. This subtitle contains provisions aimed at assisting consumers and others affected by the transition from analog to digital television broadcasts and provisions for grants to public safety agencies for communications systems. Highlights of this subtitle are as follows:

- Extends permanently the FCC's authority (which currently expires at the end of fiscal year 2007) to auction licenses to use the electromagnetic spectrum.

- Requires all broadcasters to stop their analog broadcasts and return their analog licenses to the FCC by December 31, 2008, without possibility for extension. *[Under current law, broadcasters do not have to return their analog licenses until December 31, 2006 OR until at least 85% of households in their respective service areas are able to receive digital TV signals.]* Beginning in 2009, broadcasters would have one channel in the television core (channels 2-51) on which to broadcast only in digital.

- Requires the FCC to clear the frequencies now used for channels 52 through 69 and auction them by January 7, 2008, for wireless broadband and other high-speed voice, video, and data uses (a portion has already been reserved for public safety purposes to establish more efficient, interoperable communications systems).

- Directs the FCC to report to Congress on the extent to which women, minorities, and small businesses can and do participate in the auction process.

- Reserves some of the proceeds from the auctions of licenses for the use of the returned TV spectrum in the following four new funds for direct spending by the Commerce Department:

Digital Television Conversion Fund.

- Establishes this new fund capitalized by revenues from the auctions of the returned analog licenses. In addition, the Department of Commerce (acting through the National Telecommunications and Information Administration (NTIA)) would be authorized to borrow up to $990 million from the U.S. Treasury to advance-fund and implement the Analog-to-Analog Converter Box Program (though these borrowed funds would have to be repaid from the auction sales). Caps administrative costs for this new subsidy program at $160 million.

- Allows households to affirmatively apply for up to two coupons, valued at $40 each, which could be applied toward the purchase of certain kinds of set-top boxes that convert over-the-air digital broadcast signals into an analog signal (that can be viewed on older TVs). The consumer will be required to pay the difference between the coupon and the cost of the box. Applications for coupons would be available electronically and, at a minimum, at government buildings (including post offices). The coupons, each of which would be valid for three months, would be available from January 1, 2008, through January 31, 2009 (thereby effectively terminating the program on April 30, 2009). Each coupon would be issued in the name of the applicant and would include a privacy-protected unique identifier number and other measures aimed at reducing fraud and unauthorized use. Only one coupon could be used per converter box. Participating retailers would have to be certified, and federal regulations would have to be developed to detail what kinds of converter boxes qualify under the coupon program (though no qualifying box could have an energy consumption in standby mode of more than nine watts). Finally, an expedited appeals process would be established for people who have coupon receipt or redemption problems. **Note:** Televisions that are connected to satellite or cable TV, will not need a converter box.

Public Safety Interoperable Communication Fund

- Establishes this new $500 million fund, capitalized by revenues from the auctions of the returned analog licenses, to make grants for the purchase or use of new communications equipment for public safety agencies that utilize a portion of the to-be-returned spectrum that is reserved for public safety uses.

- Requires that participating public safety agencies report to the Commerce Department on the use of these funds and agree that the federal share of any acquisition or deployment projects under this Fund be no more than 80%. Grants would be one-time payments, any unused portion of which after three years would have to be returned to the federal government. Returned funds could be re-awarded until 2010.

NYC 9/11 Digital Transition Fund

- Establishes this new fund capitalized by revenues from the auctions of the returned analog licenses. In addition, the Department of Commerce would be authorized to borrow up to $30 million from the U.S. Treasury to reimburse the Metropolitan Television Alliance for costs incurred in the design and deployment

of a *temporary* digital television broadcast system to provide digital service in the New York City area prior to the completion of the *permanent* digital transmission facility atop the to-be-constructed Freedom Tower (though these borrowed funds would have to be repaid from the auction sales).

Low-Power Digital-to-Analog Conversion Fund

- Establishes this new $3 million fund, capitalized by revenues from the auctions of the returned analog licenses, to help eligible, analog-only low-power TV stations purchase a analog-to-analog conversion device that enables it to convert the incoming digital signal of its corresponding full-power TV station to analog format for transmission on the low-power analog channel. Low-power stations would have to submit requests for compensation before 2009, and no station could get more than $400 under this program.

- Requires manufacturers of analog television receivers to put warning labels (as detailed in the legislation), on their products manufactured in the U.S. or shipped in interstate commerce, about the transition to digital.

- Requires retail distributors of analog television receivers to place warning signs in their establishments or warning language on websites or in catalogs (as detailed in the legislation) near the analog products for rent or sale.

- Requires that the FCC and the NTIA commence a public outreach program (either separately or jointly) regarding the digital TV transition and periodically report to Congress on this outreach.

- Requires cable companies and satellite distributors to include transition-TV-transition information (as detailed in the legislation) in the bills they send to their subscribers during 2008.

- Requires broadcasters to air two, 60-second public service announcements (as detailed in the legislation) about the digital transition daily during 2008—one between 8am and 9am each day and another between 8pm and 9pm each day.

- Requires TV manufacturers to include digital tuners in all sets with screens between 13 inches and 24 inches sold in the United States, effective March 1, 2007 (four months sooner than under current law).

- Requires cable companies and satellite carriers, to the extent technically feasible, to carry an eligible station's primary video stream in both standard digital *and analog* formats (without significant degradation in signal) until 2014. These companies would not have to carry a broadcaster's analog stream after December 31, 2013.

- Directs the FCC, within 45 days of the enactment of this legislation, to assess whether the returned spectrum needs to be rechannelized to accommodate wireless broadband applications. The legislation expresses a sense of Congress that the FCC should rapidly disseminate wireless broadband licenses.

New State-Government, Local-Government, or Private-Sector Mandates: As CBO reports, this subtitle does contain intergovernmental mandates "because it would impose certain requirements on television stations—more than 40 percent of which are owned by state and local entities—and would preempt energy efficiency standards in at least two states [California and New York]." State and local governments would be prohibited from passing laws that would regulate the energy consumption of the boxes.

This subtitle would also require public television stations to stop broadcasting their analog signals by December 31, 2008, earlier than is likely under current law. However, CBO reports that most publicly owned television stations have already made the transition to digital television and would realize savings of up to $100,000 per station in electricity costs when they turn off their analog signals. These stations would be required to air two 60-second public service announcements each day in 2008 about the transition to digital service.

The subtitle also includes a number of private-sector mandates, as follows (paraphrasing CBO):

- Broadcast stations would have to terminate analog television service on December 31, 2008;
- Manufacturers, retailers, broadcasters, and cable and satellite service providers would have to educate consumers about the digital transition (including by running public service announcements at specified times each day in 2008);
- TV manufacturers would have to include digital tuners in all sets with screens between 13 inches and 24 inches sold in the United States, effective March 1, 2007 (four months sooner than under current law); and
- Cable companies and satellite carriers would have to carry certain video streams that can be received by digital *and analog* televisions.

RSC Staff Contacts:

Subtitle A, B, C: Joelle Cannon; joelle.cannon@mail.house.gov, (202) 226-9717

Subtitle D: Paul Teller; paul.teller@mail.house.gov, (202) 226-9718